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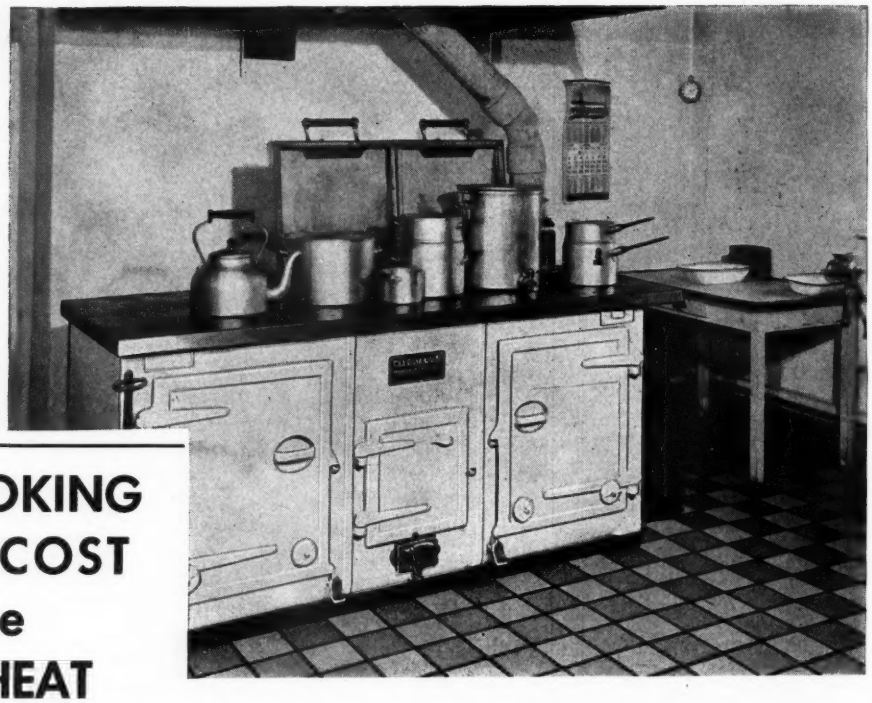
TORONTO, SEPTEMBER, 1940

THE CANADIAN HOSPITAL

· OFFICIAL JOURNAL · CANADIAN HOSPITAL COUNCIL ·



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Harvey Agnew, M.D.,
Editor

The CANADIAN HOSPITAL

Toronto, September, 1940 Vol. 17 No. 9

The Duties of a Hospital Trustee

REV. J. R. MacDONALD,
President of St. Martha's Hospital Board of Trustees, Antigonish, N.S.

BEFORE outlining the specific duties of a hospital trustee, may I refer briefly to certain *qualifications* without which no one can successfully fulfill those duties? The most important of these qualifications is a desire to be of service to others and to contribute to their welfare. A selfish person cannot be a successful director of a public service of this kind. One must be willing to give the necessary time and labour without thought of personal reward, either in the way of business or of prestige. Because hospital work is based primarily on sympathy and concern for those who are suffering, everyone associated with it must be inspired by that spirit of Christian charity, which, from the beginning, has been the dominant motive in the care of the sick. A hospital trustee must also have a reputation in his community for integrity of character and for sound and sane views, for it is important that the public have confidence in those who direct community institutions, established and maintained by the people's money. For the same reason, he should have proven himself previously to be possessed of business ability or of other capacities which fit him to serve the hospital's needs.

Duties and Responsibilities

Having said that much concerning the personal qualities necessary in a trustee, I would say that his first duty is to attend the Board meetings regularly. If he is unable or unwilling to do so, he would confer a favor on the hospital by resigning.

At the Annual Meeting of the Board, it is the Trustee's important duty to see that the best persons available are chosen as executive officers. No trustee should accept an office unless he is prepared to devote the interest and time required. At all meetings, every trustee should be prepared to take an active part in discussions and to act, if appointed, on Committees. Many Boards make the mistake of leaving all the work to one or two members.

Adequate Knowledge Essential

Every trustee should have an adequate knowledge of the nature of his trust. He is to help direct the operations of a highly complicated and technical community service, and the better informed he is on the business and professional aspects of that service, the more effectively will he be able to carry out his duties. To this end he should, from time to time, visit the various departments of the hospital and learn at first hand what each is doing and with what specific problems each has to contend. Perhaps the best way of doing this, would be for the superintendent to arrange for all the trustees to make such a visit quarterly or semi-annually, at a time when the heads of departments are free to explain matters to them.

In suggesting that a trustee should get first hand acquaintance with all phases of the hospital, I do not wish to imply that there should be any interference on his part with the administrative work. The Board of Trustees appoints the superintendent to administer and direct the work of the hospital, and no trustee

A Trustee is one to whom the guardianship of something valuable and the directorship of something important is entrusted. The hospital is a valuable asset to the community and has valuable property and interests to be protected; moreover, the work of the hospital is a highly important professional and business undertaking, requiring careful and scientific direction. A hospital trustee is, therefore, both a guardian and a director.

should go over the head of the superintendent or interfere with those serving under her. If there is fault to be found with any official or employee of the hospital, the place to deal with it is at the meeting of the Board, where all suggestions and complaints may be discussed in a fair and orderly mannner, and action, if necessary, determined jointly.

It is a real asset to a trustee to have some knowledge of problems common to all hospitals. This knowledge he can acquire by attending hospital conventions and regional conferences, and also by familiarizing himself with publications in the hospital field. The annual report of the Provincial Department of Public Health should be studied carefully by every hospital trustee.

It may be too much to expect every trustee to have an all-round knowledge of hospital work. A service which operates day and night, the year round, and which combines business, professional and educational services all in one institution, can be fully understood only through prolonged study and extensive experience. A trustee many prefer to delve more deeply into one or other of the various activities and, in this particular field, he could well become expert enough to be of special value to the Board. But he should also have sufficient acquaintance with all phases to be able to join with his fellow-members in intelligent discussion.

Proper Functions of the Board

The American Hospital Association in 1924 laid down the following as the functions of a hospital Board of Trustees:

(1) To determine the policy of the institution based on the needs of the community which it serves,

(2) To see that the hospital maintains proper professional standards,

(3) To co-ordinate the various departments of the hospital so that the whole institution may function efficiently in the interests of the patients,

(4) To arrrange for satisfactory financing and for business-like control of expenditures.

Possessed of the qualities outlined in the beginning of this paper, and armed with a knowledge of his duties, a hospital trustee is equipped to fulfill those four functions in a satisfactory manner.

Because trustees usually select an efficient superintendent and because the medical staffs are usually highly competent, the work of Boards of Trustees is concerned mostly with the problem of finance. As one authority advises, they must "face budgets with courage, deficits without dismay" and they must "recover quickly from a surplus". The last part of this advice is unnecessary for most hospitals, since a surplus is almost unknown.

Finally the hospital trustee should be proud of the status and traditions of his hospital, and he should be loyal, under all circumstances, to its interests. May I say, in conclusion, that there are two extreme situations to be avoided. One exists when the Board allows itself to become a mere rubber-stamp for the superintendent; the other, when the Board assumes dictatorial domination over the administrative and professional staffs. Mutual confidence and respect, and a spirit of co-operation, will develop a system of hospital management in which the best interests of the sick are provided for.

Our hospitals are democratic institutions, built by the people, operated for the people, and directed by Boards, the members of which represent the people. The State helps financially by grants and requires certain standards, but again the democratic State is only the people operating through their elected representatives. We are pledged to maintain this democracy—not only in the field of health but in all our institutions and in the general field of national policy. In these days, when the free democracy we cherish is threatened, it is our duty to uphold and strengthen it. As hospital trustees we represent the public; let us administer our trust to the best of our ability in the interest of those whom we serve.

Address, Hospital Association of N. S. and P. E. I., Bridgewater, N. S., June, 1940.

Approval for Internship List Announced

The 1940 revision of the list of hospitals in Canada approved for internship just released by the Department reveals that there are now 816 internships available in the 53 approved hospitals. These include 195 final year internships for those students whose final year is an internship one. The number of hospitals on the "commended" list is 8, offering 16 graduate and undergraduate internships.

Autopsy percentages on the whole appear to be higher than they were last year, the Children's Memorial Hospital leading the list with 94.2. It is worthy of note that the Vancouver General Hospital, one of the largest in Canada and a non-teaching hospital, stood third on the list. The high percentage of the Jewish General Hospital in Montreal, despite special difficulties, is most commendable.

Children's Memorial Hospital, Montreal	94.2%
The Montreal Children's	86.1
The Vancouver General	76.2
The Montreal General	75.7
The University of Alberta Hospital	65.6
The Jewish General, Montreal	61.8
Hopital de l'Enfant Jesus, Quebec	61.4
Royal Victoria, Montreal	61.3
Hospital for Sick Children, Toronto	60.06

Three hospitals were added to the "approved" list this year—The Homoeopathic Hospital, Montreal, the Holy Cross Hospital, Calgary, and the St. Paul's Hospital, Saskatoon, the latter being reinstated as an approved hospital.

The Italians are like crows which feed on carcasses and hover about battlefields in the hope of something being left for them to devour.

—Bismark

Planning the Morning Conference

An Ideal Method of Supplementing the Formal Lectures

REV. SISTER M. EVANGELISTA,
St. Joseph's Hospital, Winnipeg

TO-DAY we seem to be in an era of unrest in the world of nursing—an era of dissatisfaction with ourselves and our profession. The whole question revolves about the old controversy of "Trained Nurse", versus, shall we say, the "Educated Nurse". But just as surely as this debate goes on, popular opinion is slowly and certainly veering toward the "Educated Nurse". We are relegating to the background the older type of nurse, splendid in its kind, yet not so sufficient in this day of highly specialized service to the sick. But shall we turn the wheel too far; shall we become victims of "Germ Education" without practical application to our teaching; shall we be graduating pupils educated in theory and yet ignorant in practice? The answer lies with you, each educator, each supervisor in the field of Nursing Education to-day.

We look back upon our school days—in grammar school, in high school and, perhaps, in college, and standing out before our mind's eye, we see subjects long past forgotten, for how many of us could to-day solve an algebraic equation or a geometry theorem? How many of us know or care what rule in physics governs the refraction of light? Why? It is because we have found no practical application for these subjects in our chosen walk in life. But have we forgotten how to write; how to spell; have we forgotten those first principles of chemistry? No! And why? Because we find in our daily life a practical, forceful and necessary application for each.

Let us now turn to the "School of Nursing Education". We are educating our nurses; lectures to-day by doctors and instructresses have become many and varied. Are we going to fail in bringing home to the pupil nurse the lessons taught in the class room? We hope not. We must find some link between all this theory and the fulfillment of it in the practical work on the wards. *That link is the Morning Conference.*

The well planned programme of the Prairie Provinces Conference, Catholic Hospital Association, resulted in a fine turn-out for its recent meeting. This picture of delegates was taken in front of the Holy Cross Hospital, Calgary, Alta.

The Morning Conference

The Morning Conference must follow a definite educational programme: it must have a definite plan and must give to the pupil nurse something concrete, something tangible. Through the morning conference a nurse must be given eyes to see, a mind to think, and a will to do. In other words, the morning conference must be the complement of the lectures given in the class room. Your series of morning conferences must be just as well planned as the lecturer's have been. On your shoulders rests the responsibility of the nurse's interpretation of a whole course of abstract terms and theories. For instance, in the lectures on cardiology, the lecturer has probably told the nurse that the patient must have "absolute rest". It is through you that the nurse will receive the correct conception of the word "absolute". She will learn methods of inducing this absolute rest. She will be told that besides sedatives, seemingly minute details, such as plenty of sunlight, quiet surroundings, light but warm bedding, a comfortable position in bed, and anticipation of the patient's wants will make a maximum of difference to her patient.

It has been said that "medical diagnosis" is essentially an art, and the artly use of clinical manoeuvres must always outshine the cold science of test tube and microscope. One symptom discovered is of infinitely more value than a whole list of signs. If, then, the medical profession places so much importance on the complaints of the patient, how necessary it is for us as their co-workers to be able to sift the grain from the chaff, as it were, and place before them the important symptoms we have assembled as the result of our observation of the patient. All this brings us to the conclusion that not only we, but our student nurses, must know the danger signals of the disease with which we are working.

A Seven-Day Programme

Personally, I think nothing spectacular should be used as a subject for morning conference; rather should the subject be chosen from types of disease such as heart disease, diabetes, nephritis, etc., leaving the rare, the outstanding, for bedside nursing clinics. A definite outline for the study of any disease should be made and then followed to the best of our ability. In this way, one also teaches the pupil how to study a disease intelligently and methodically. For example, I will here quote my own outline. Nurses are assigned to the medical floor for a period of nine weeks. I, therefore, choose nine subjects for morning conference and arrange each subject to cover the space of seven days, or one week. Each individual topic then has its own subheadings, which always follow the fixed outline established.

Textbooks are used voluntarily, but the students are encouraged to use them only to supplement their own observations. They should rather be encouraged to discuss these patients as to their symptoms among themselves, or even better with the doctor in charge of the patient. Nurses are too apt to memorize a list of signs and symptoms from a text and then fit the patient into their mental picture. To be referred directly to the patient as the principal means of information will make them more observant, more interested, and will lead more readily to the discussions we are trying to encourage. Then if reference be used, the nurse is more likely to keep before her the individual picture she has formed and add to it the other signs and symptoms of the text as those which "might have been". I am not discouraging textbooks and reference books. They are not only useful but necessary; however, for the purpose of quickening the student's observation, they should be made second only to the nurse's original picture. We are attempting all through her education to make the pupil nurse "see her patient" as the individual—to make her observant.

The routine is as follows: first day anatomy and the physiology of the normal organ or system for study; second day — abnormalities of this organ or system during the period of disease and disability. Students are then referred for observation to definite patients on the wards suffering from this disease or types of this disease.

On the third, fourth and fifth day the nurses' observations from patients and charts are considered and the nurse is guided to choose the important signs and symptoms. Other symptoms not mentioned are given and the complications of the disease are discussed. Treatment of disease, general and specific, the medications used and any new literature on the subject are dealt with; for example in a discussion on pneumonia, the treatment of pneumonia by serum

(*Continued on page* 48)

EXECUTIVE COMMITTEE OF THE P. P. C., C. H. A.

First row: Sister M. Veronica, Moose Jaw; Mother Mann, St. Boniface; Sister M. Beatrice, Lethbridge, President; Sister Anna Keohane, Vegreville; and Sister D. Clermont, St. Boniface.
Second row: Sister A. Herman, Saskatoon; Sister Alice Marie, Winnipeg.
Third row: Sister M. Emmanuel, Lethbridge, Secretary.

Relationship of the Medical Colleges to Intern Training

Discussed by Joint Relations Council on Medical Education, Licensure and Hospitals

THE second annual conference of the Joint Relations Council on Medical Education, Licensure and Hospitals was held in Toronto on June 18th in conjunction with the meeting of the Canadian Medical Association. At this conference representatives were present on behalf of the medical colleges of Canada, the Medical Council of Canada, the provincial licensing bodies, the Canadian Hospital Council, the Canadian Public Health Association, the Royal College of Physicians and Surgeons of Canada, and the Canadian Medical Association and its various provincial divisions. The Canadian Hospital Council was represented by its president, Dr. George F. Stephens.

Among the topics discussed was that of the relationship of the medical colleges to intern training. The importance of the internship in training for medical practice and the desirability that it be developed as a link in the chain of medical education was emphasized. Dean J. J. Ower of the University of Alberta stated that a lot of hospitals and their medical staffs are using interns as servants, not as apprentices. The number of approved internships available exceeds the number of men being graduated but, if a more rigid method of inspection were set up, the number of internships could be radically reduced.

The importance of linking up the medical college with the internship was stressed by several speakers. It was suggested by one delegate that a large hospital away from a teaching centre might become affiliated with a medical college by taking its graduates as interns. There was much discussion of the revised curriculum at McGill whereby students receive their degree at the end of the fourth year, but must spend the fifth year either as a hospital intern or in a laboratory before being given the licence to practise in Quebec. Actually, the academic instruction is not curtailed, for each of the four years has been lengthened from thirty-two teaching weeks to forty teaching weeks.

Dr. George F. Stephens endorsed many of the statements made in the recently published report of the Commission on Graduate Medical Education prepared by a committee under the direction of Dr. Willard Rappleye of Columbia and Dr. R. C. Buerki of Wisconsin. He pointed out that the main idea for intern training is to develop the family doctor but that it should also lay the groundwork for further study leading to the practice of a specialty. Two years of internship is desirable for general practice.

The ever present problem of interns leaving the hospital before completion of the twelve months' service contracted for was again raised. Dr. Otto Niemeier of Hamilton urged that some way be developed of making the completion of the internship year obligatory. (At the present time the completion of the internship year before obtaining a licence to practise is not obligatory in any province, although practically all applicants for licence have had an internship. Most registrars are favourable to making the completion of an internship part of the essential background for the licence.) Delegates from a number of the medical colleges described how their own universities have endeavoured to get over this situation by incorporating the internship in the medical course.

The value of an internship in a non-teaching hospital was pointed out by Dr. E. S. Ryerson, of the University of Toronto. He was of the opinion that for the man going into general practice the internship in a good non-teaching hospital was often of more practical value than one in the teaching hospital. The experience obtainable by the first-year intern is often better in the non-teaching hospital.

Canadian Intern Board

The work of the Canadian Intern Board in clarifying the confusion which has long existed over the appointment of interns was outlined and the efforts of the Board were commended. Some apprehension was expressed by one teacher lest the Canadian Association of Medical Students and Interns lead to the development of the trade union idea, the criticism which has been frequently made of a similar organization in the United States. However, it was pointed out that this organization is founded upon very sound lines, has a capable advisory board and is not likely to take that direction.

Post-Graduate Training in Hospitals

The various ways in which the hospital could participate in post-graduate instruction in medicine were considered. Examples of successful short refresher courses, as at Vancouver, Halifax, Port Arthur and Toronto, were cited. The importance of the medical library in each hospital was urged.

A resolution favouring the elimination of the two examinations now required of graduating medical students was passed. At the present time students must write their final examinations, wait a few weeks and then write parallel examinations for their licence to practise, in many instances having to sit to the same examiners. While there is general agreement that much of this duplication could be eliminated, the actual machinery to arrange for such is somewhat complicated.

Much discussion took place also with respect to the refugee physician. In the discussions it was brought out that in one province (Ontario) six refugee physicians are now serving as interns.

GALLOWS KNOLL

A Unique Hospital Link with the Halifax of Yore

CLAIRE HARRIS MACINTOSH

APPROACHING the Victoria General Hospital, Halifax, one is impressed by the unusually extensive lawns, the beautiful trees and the long encircling driveways. To those who know the stirring history of "The Knoll," near the centre of these grounds, much interest is added.

The story, which reads like a chapter of fiction, is, unfortunately, a true one. It is also gruesome, as those of pirate days often are.

The chief character in the drama was a Captain George Fielding who, in 1842, set sail from Liverpool, England, for South America as master of the barque, VITULA. He took with him his fourteen year old son and a crew of fourteen.

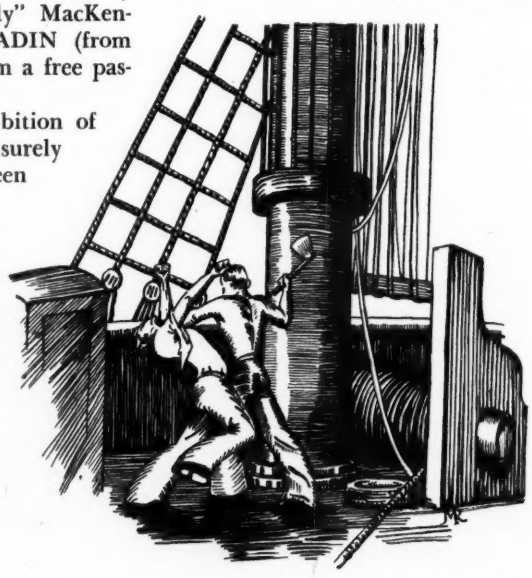
Buenos Aires was visted, and then Valparaiso, but business was disappointing and he decided to make an attempt to smuggle a cargo of guano from Peru; for this purpose he followed the coast to the island of Chincha. The government, however, heard of his intentions and sent a force of fifty soldiers to seize his ship. Fielding resisted but was wounded, his boat captured and he, himself, placed in hospital. When able to leave he was allowed the liberty of the port and at once began scheming to take his vessel out of the harbour at midnight. His plan was discovered and he was put in prison. With the help of his young son he escaped, and after hiding for two days in some shavings, they found refuge on a British steamer and reached Valparaiso once more.

Fielding now faced disgrace and financial disaster. He and his son sought passage to a British port but were refused. He, however, finally persuaded Capt. "Sandy" MacKenzie of the barque SALADIN (from Newcastle) to give them a free passage to London.

Then began an exhibition of gross ingratitude which surely has seldom, if ever, been excelled. The mutual dislike of the two captains grew to hatred and, with Fielding, to jealousy. He had lost his boat. Why not, he argued with himself, seize the beautiful SALADIN and her rich cargo of silver and copper? Capt. MacKenzie told him that during the last twenty years he had made sufficient money to enable him to retire and this was his last trip before doing so. Fielding vowed to himself that he would make quite sure that it really would be MacKenzie's last trip! It was merely a matter of mutiny on the high seas!

Stealthily he picked his men, bribing them with promises of rich rewards. As for the other members of the crew whose loyalty to Capt. MacKenzie was apparent, they would die along with "Sandy"!

George Jones, the sail-maker from County Clare, a cripple who, like



Claire Harris MacIntosh, who in private life is the wife of Dr. Geo A. MacIntosh, General Superintendent of the Victoria General Hospital, Halifax, is an author of note whose works of prose and poetry and whose pageants are well known to Canadian readers.

long John Silver, wore a peg leg, was first won over with bribes. Young Galloway the steward, Bill Johnson the red-haired man, John Hazelton and Anderson the Swede became his tools. Fear seized these young lads, none of whom were over twenty-three years of age, but once in the secret they knew it was death for them also if they failed to carry out Fielding's orders.

It was during a night watch that, one after another, the victims were slain—first, the mate, with carpenters' tools, as he slept on the deck. His body was thrown overboard. As the carpenter came up the hatch he was stunned with hammer blows and thrown into the ocean, but the water revived him and he cried out. This gave Fielding an opportunity which he seized; the shouting of "man overboard" brought Capt. MacKenzie hurrying up the companion-way. As his head appeared he was struck, but he vigorously fought his opponents finally succumbing to the blow of an axe from his "guest" passenger. Three other members of the crew were then killed and their bodies disposed of in similar manner.

The ship's course was then changed and headed toward Newfoundland, the mutineers taking over at Fielding's command while he spent his time drinking and gloating over his treasures.

Dawn broke into a radiant Sunday morning. Fielding called the other murderers into the cabin, brought out his Bible and, in turn, each man kissed the Book and swore to be loyal and brotherly to each other. Already, however, there was an atmosphere of suspicion — another mutiny was brewing!

The members of the crew had reason to believe that Fielding was plotting their lives in order to be sole owner of the ship and cargo. He was seized, gagged and bound and his fate discussed by the blood-stained crew, as he lay before them. They were not safe, they argued, while such a traitor lived and so he and his son (also implicated) followed the fate of those who, at his command, had so recently found an ocean grave.

With all sails set the SALADIN neared her end. On May 22, with her drunken crew on board, she drove hard on the island at the mouth of Country Harbour, Nova Scotia, at a place ever since known as Saladin Point.

Confusion reigned as the boat was boarded by would-be rescuers. The story of the six sailors did not agree and they were, forthwith, arrested and brought to Halifax. The blood-stained, death-ship *Saladin,* became a total wreck. Her figurehead which was, in accordance with her name, a turnbaned Turk, was brought to Halifax and is still preserved as a souvenir. The soul of the ship, however, sleeps in the deep with her motely crew.

The six men were jailed in the provincial penitentiary on the North West Arm. Day after day they gazed at this beautiful expanse of water and verdant hills beyond, and repented. Each, of his own accord, wrote and signed a confession depicting the hideous occurrences.

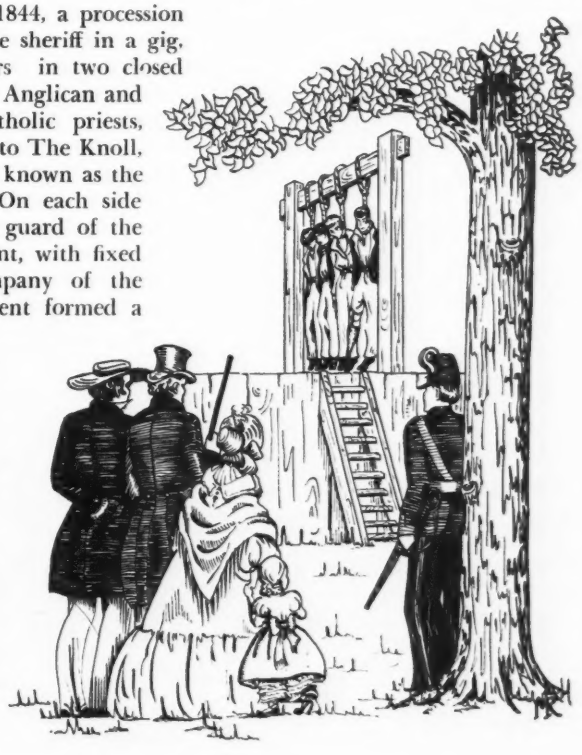
As the murders had been committed on the high seas, outside the jurisdiction of any Nova Scotian Court, a special court was constituted. This was held in what is now the library of the Province House. The Admiral of the station, in full naval uniform, sat as judge and with him were the Chief Justice and three puisne judges. Four of the criminals were found guilty and sentenced to be hanged.

On July 30th., 1844, a procession which included the sheriff in a gig, the four murderers in two closed carriages, and one Anglican and three Roman Catholic priests, wended their way to The Knoll, on what was then known as the South Common. On each side marched a strong guard of the 1st Royal Regiment, with fixed bayonets. A company of the 52nd Foot Regiment formed a circle around the scaffold and kept the large "audience" at a distance. The writer was privileged to meet Mrs. Lenoir, an esteemed citizen, who died recently at the age of one hundred and three. Mrs. Lenoir, when a child, was present on the occasion of these executions, having been taken there by her elders.

We will not dwell on the executions—the climax of the tragedy. Following the simultaneous deaths the bodies were committed for burial. The Earth, not the Sea, received them. Their story lives on in ballad form and in the occasional quests by treasure seekers for pirate booty from the Saladin. In keeping with the whole sad affair the exhumed skull of one of the gallows' victims has since been used to teach anatomy to medical students.

To-day the Gallows Knoll adds to the beauty of a hospital's grounds. No gibbering, sheeted apparitions haunt it on moonlit nights and, contrary to the old citizens' tales, no ghostly procession drifts noiselessly once each year through the streets of Halifax to its grassy slopes. Much travelled paths encircle the mound thus setting it apart, but the paths continue and lead to an institution of healing, of life-giving and saving, —an institution where human sympathy, understanding and skill unite for the benefit of mankind.

The knoll is in the middle distance to the right in the photograph on the opposite page. The hospital buildings are grouped along the higher ground beyond this spacious lawn and may be faintly seen through the trees.



Will There Be More Specialization in Bedside Nursing?

A Dean of Nursing Studies the Trend Toward Specialization

By Sister M. BERENICE, R.N.
Milwaukee, Dean, College of Nursing, Marquette University

SHOULD there be more specialization in medical and surgical nursing, i.e., would it benefit the patient, the doctor, the nurse, and/or the hospital? We all agree that the patient should be the first consideration in this question; you can shift the doctor, nurse and hospital around in whatever succession you like.

Post-graduate courses in the clinical specialties have been common for years. They were taken usually by those preparing for positions as head nurses or supervisors and great regret was felt that little or no preparation for these positions was included in the average "p.g." course. Frequently these so-called courses were simply three, four, six, or twelve months of additional experience with a little class work thrown in. Undoubtedly there are some good courses being offered at this time. At our institution we are trying to offer honest-to-goodness post-graduate courses, but they are frankly for the head nurse and supervisor and include special preparation for such positions, as that is the demand being made today. In some states a post-graduate course or its equivalent is required for head nurses, for supervisors, or for both. Progressive nurse educators agree that head nurses and supervisors should be specialists in their fields, even though not all are, by any means.

The question before us is: should there be specialization for the medical and surgical bedside nurse, or should they continue, as most of them do, staff, private duty, and visiting nurses, to care for any or all types of patients, not only medical and surgical, but obstetrical and pediatric as well?

Address, A-C-S Hospitalization Conference, Detroit, April, 1940.

Combined Training

In the last revision of the National Curriculum (U.S.A.), the theoretical courses in medical and surgical nursing, formerly separate, were combined, with the specialties as units in the course, instead of distinct and separate little courses.

We have found advantages in using the combined course in medical and surgical nursing, even though not all the problems it presents have been worked out to our complete satisfaction. Time is saved by avoiding useless repetition of anatomy, physiology, symptoms, and treatment. The student gets a more integrated and connected picture and since her patients are often combinations of medical and surgical conditions, why try to separate the two into distinct entities?

No doubt we nurses have all said at least once, and thought many more times, that specialization—learning more and more about less and less— is dreadfully narrowing. We have seen the eye man who is inclined to look upon the eye as the root of all evils, and wants three more hours to complete his course in the subject, the surgeon who wants to rush out the offending organ if life can possibly go on without it, the medical man prone to try all his remedies before the surgeon is permitted even to peek through the door at the patient, and the bone man who is more likely to find a bone misbehaving than anything else. The general practitioner, impartially doing a little bit of everything, even though without a certain degree of finesse in any of them, has a much wider selection of fields from which to choose his diagnosis. It undoubtedly takes a very broad base of good general diversified professional knowledge and practice to support the narrow, pointed apex of specialization. Doesn't the nurse who specializes become narrow too? Doesn't her field spread out and practically cover her whole horizon,

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Huns Destroy Red Cross Train

This is the interior of a French Red Cross hospital train bombed by Nazi aviators. This coach had a distinct Red Cross on the roof as well as on the sides. Despite these internationally recognized protective markings, the ruthless barbarians utterly destroyed this entire train by bombs and machine guns.

thus causing knowledge of other equally important fields to fade sometimes to the point of disappearance?

Analyze nursing: it is about three-fourths, maybe seven-eighths, personal hygiene—keeping the patient clean, mentally and physically comfortable, and well fed. The other small fraction is specific care of the particular disease or condition from which the patient is ill. List the treatments and nursing procedures the nurse utilizes in bringing her patient, medical or surgical, back to health. There is not a procedure nor a treatment (barring surgical dressings) which she does not use at some time or other for either type of patient. Why then specialize in one or the other? Isn't the nurse who has a good, all-round knowledge of both better than a specialist? So it might very reasonably seem, and so it seemed to me from a purely logical and theoretical point of view.

The young graduate who has completed a good course in nursing, including a broad variety of fields (not merely the four basic services), should have a year of general nursing experience not confined to any particular field. This year of general experience would be for her benefit, not the patient's, though it is recommended with the idea that eventually the patient would be the beneficiary. After this year, the nurse who desires to continue in bedside nursing could then well begin her specialization in the field of her selection—medical, surgical, or other.

Special Attributes Essential

Although the care of both medical and surgical patients is rapidly progressing, new remedies and treatments being constantly devised, one's reasons for desiring specialization are not primarily because of lack of familiarity with treatments and care in general, although these naturally are important factors. A more important, and more highly specialized phase of surgical nursing is the ability to recognize immediately and report intelligently changes, complications, and crises in the surgical patient. The nurse is the eyes, ears, nose, fingers and mind of the physician when he is not around. She has the opportunity, far more than either the attending physician or the intern, to observe the patient closely and frequently and her trained senses, quick appreciation of signs and symptoms, prompt and intelligent reports, and necessary emergency treatments, will often avert serious and even fatal consequences. It takes a long period of good, careful, and extremely conscientious nursing experience, combined with intelligent correlative study, to develop the ideal bedside nurse for the surgical patient.

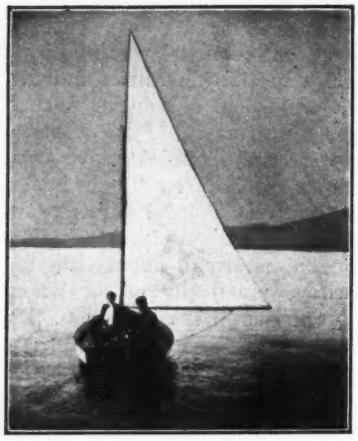
The grade A medical nurse has a thorough knowledge of all the fundamentals underlying the care of the medical patient, whether his disease is infectious, communicable, or absolutely non-transferable. She has the numerous diagnostic procedures at her finger tips, she knows to a nicety the restrictions and liberties of the acute and chronic patient, no matter what his disease. This is no mean art; it requires experience, patience, intelligence, and knowledge both theoretical and practical.

It takes a staff nurse, with a good general background of experience, about six months to become thoroughly reliable and efficient when placed in either the medical or the surgical departments of our institution. A good nurse can become a very satisfactory medical or surgical nurse after a year of consecutive experience under skilled supervision, in a first class institution. It takes several years to make an ideal or exceptional medical or surgical nurse from a nurse who is capable of a high degree of development. *It would seem to be quite as expedient and desirable for the private duty nurse to specialize as for the staff nurse.* Instead of having all private nurses registered for work at the hospital, called for all types of cases, let each select her field and remain in it, proportions being worked out as nearly as possible according to local needs. What may be feasible in the large city and large hospital may be less practical in the small town and small institution, but, once convinced that we need specialization, much could be done to approximate the ideal, even in smaller places.

Once convinced that specialization is desirable, who ought to introduce and urge forward such a programme? The nurse educator, who can persuade and convince the student nurse while still in school; the nurse administrator who can insist that staff nurses, at least the majority of them, be comparatively stable in that department in which they seem to adjust best, and who can also urge private duty nurses to become expert in one type of nursing service and register in this field, even though they respond to emergency needs in other fields of service; registrars in charge of professional registries, who can use their influence with private duty nurses and help to pave the way for specialization by making specialization easy and attractive to the nurse and by filling requests for nurses carefully and intelligently; hospital superintendents, who can help by listening to the pros and cons of the subject, allowing themselves to be convinced and co-operating in the efforts of directors of nursing service and supervisors.

An Ideal Method of Uniting the Americas

DR. OTHO BALL, president of the Modern Hospital Publishing Company, has at last produced the volume which has long been in his mind as a very desirable means of effecting closer relationship between the Spanish speaking and English speaking peoples in the three Americas. Last month there was issued the first edition of El Libro del Hospital Moderno, a beautifully prepared and illustrated reference library or year book, written entirely in Spanish. This volume might be described as epitomizing between two covers the essence of hospital progress in the United States. The material has been based upon the requests coming from Spanish speaking countries and covers a wide field of subjects, including construction, organization, nursing, and administrative and technical procedures. There is also added a very helpful directory of equipment and supply houses. The contributors are all outstanding authorities, practically all of whom have international reputations. Dr. Ball and his associates are to be congratulated upon the issuance of this first hospital reference book in Spanish and upon the fine spirit which has been shown in endeavouring to bring about closer international relations.



"The Laverock", in which Mr. Antle made his first survey of the Columbia Coast Mission Territory in 1904.

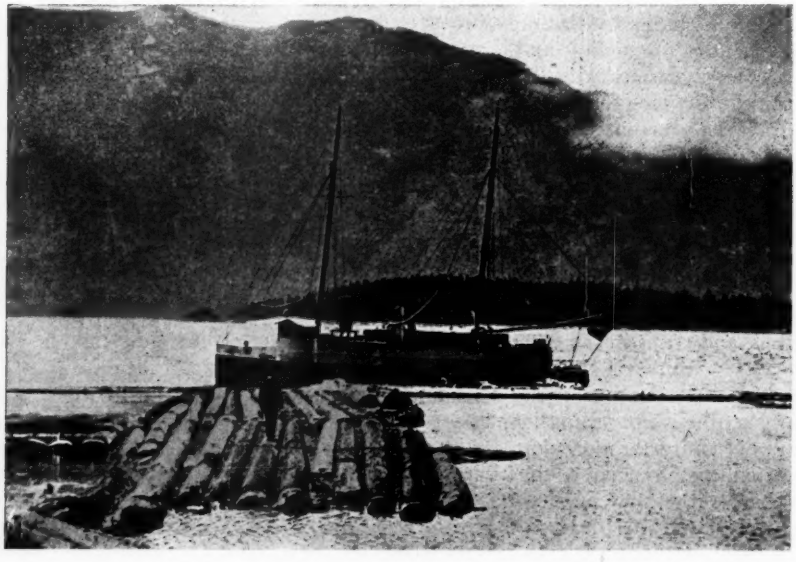
Columbia Coast Mission Celebrates Thirty-Fifth Anniversary

THE Columbia Coast Mission recently celebrated thirty-five years of service to a territory which covers 20,000 square miles of sea and land. This unique service began when the first "Columbia" was dedicated at Victoria, April 29th, 1905, and immediately left for the mission waters. During the previous year a survey of the territory had been made by the Rev. John Antle, founder of the Mission in "The Laverock", a 14-foot motor driven sailboat. The "Rev. John", as he was called by those who knew and loved him, was the leading spirit of the Mission for many years; from 1905 until 1936 he held the position of superintendent of the Mission. A true "skipper", Dr. Antle, now retired, has just completed a trip through the Panama Canal and up the Pacific, in the 48-foot yacht "Reverie". Rev. Alan D. Greene, who joined the mission in 1911, is the present energetic superintendent, and Mr. Ben Drew is secretary, with headquarters at 198 Hastings Street W., Vancouver.

An excerpt from the First Annual Report of the Columbia Coast Mission, dated January, 1906, reads: "But the work is only successfully begun; it is still to do, and the field opens up infinitely vaster than we could foresee." At that time the Mission's "assets" consisted of the following: 1 hospital (Rock Bay) 1 doctor and 2 nurses, 1 hospital ship ("Columbia"), 1 clergyman, 1 secretary-treasurer—a total staff of five. The challenge of the field that "opens up infinitely vaster than we could forsee" has been answered nobly. The work has grown steadily and the mission now includes: 3 hospitals (St. George's Hospital, Alert Bay; St. Mary's Hospital, Pender Harbour; and St. Michael's Hospital, Rock Bay), 2 hospital ships (the

Left.—The Rev. John Antle, D.D., Honoris Causa, Founder and Superintendent of the Columbia Coast Mission from 1904 *to* 1936.

Below.— The old "Columbia", built in 1905, *is here seen on a wintry day at Rock Bay.*



The opening and dedication of the first Mission Hospital, built in 1905 and known as Queen's Hospital, Rock Bay.

The Rev. Alan Greene first joined the mission in 1911 and became superintendent in 1936.

A patient being brought on board the hospital ship "Columbia", showing the crew, Capt. Ed. Godfrey, Dr. Stanley Mills, Mr. Cecil Fitzgerald and Tony the cook.

Kingcome Indian Girls in ancient costume.

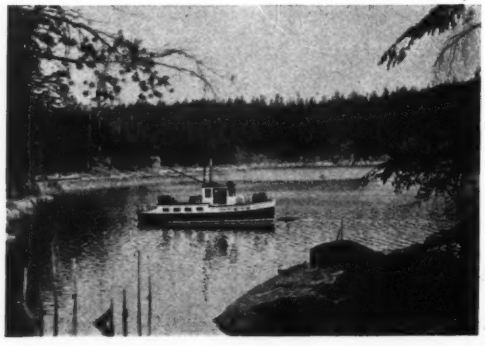
Below.— The Mission Hospital Ship "John Antle" entering Princess Louisa Inlet at the head of Jervis Inlet.

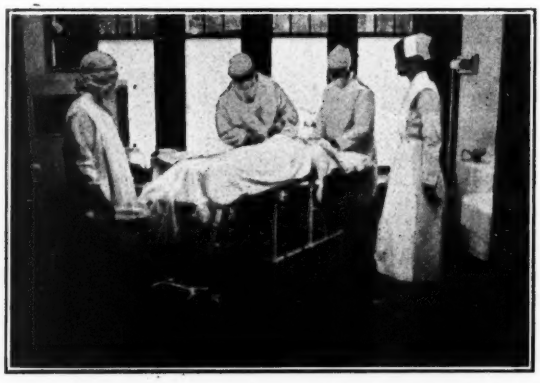
Below and right.— Ben Drew, Secretary of the Columbia Coast Mission, taken on board the "Columbia".

Above.—Mission Ship "Fredna" on patrol some years ago.

St. Mary's Hospital and Chapel at Pender Harbour, fifty miles up coast from Vancouver.

Below.—The Mission Ship "Rendezvous" at anchor in Blind Creek, Cortez Island.





An operation in progress in St. Mary's Hospital, Pender Harbour.

"Columbia" and the "John Antle) and 1 mission ship the "Rendezvous", 5 doctors, 13 nurses, 2 clergymen, 2 school teachers, 4 office staff and 22 employees in the hospitals and on the ships.

One of the newest features of the work was undertaken very recently at St. Mary's Hospital, Pender Harbour. In keeping with the present day trend toward hospital care insurance, St. Mary's Hospital, which carries contracts for hospitalization with many of the men in the logging camps, has engaged another doctor and, as an experiment, is including the loggers' and their dependents in a hospital care plan which also offers medical benefits. The three-months experiment offers medical and hospital services at a rate of $1.25 for single men and $1.75 for married men and their dependents.

Recently when the "John Antle" was on her way up Jervis Inlet one of the main bearings showed signs of burning out and a passing boat towed the "John Antle" to a sheltered spot for the night. While the skipper and the cook-engineer worked to replace the defective bearing, a call came over the radio-telephone from Dr. Sanders at Rock Bay asking for the assistance of Dr. McKichan on the "John Antle" at a critical operation. The skipper and engineer worked all night on the bearing and at daybreak set out on the long 100-mile run to Rock Bay where they arrived in time for the operation. The patient, who had a ruptured appendix and had been brought in to St. Michael's Hospital by the Rev. J. D. Addision, skipper of the "Rendezvous", made a very satisfactory recovery after the operation.

The everpresent problem is that of raising sufficient funds to permit this most essential service to go on. Were it not for the kind support of interested friends all over Canada and from further afield, it would not be possible to continue this work.

Poet in Hospital

William Ernest Henley, the author of the famous lines "I am the master of my fate, the captain of my soul", spent some twenty months as a patient in the old Edinburgh Infirmary at one time in his career. During his stay he composed a whole series of poems. Unfortunately for Henley, too many of them were, to quote Nursing Illustrated, "alike in grim detail and melancholy observation" and editors promptly refused them. It is our guess that he had a peptic ulcer, perhaps with biliary complications.

Care of Psychiatric, Alcoholic or Suicidal Patients in General Hospitals

As a result of an enquiry made to the Department of Hospital Service of the Canadian Medical Association, a questionnaire was sent out to a number of the larger Canadian Hospitals with respect to the type of accommodation provided for patients admitted for investigation to public wards and found to be mental, for acute alcoholics, and the type of protection provided for attempted suicide cases. For the purpose of comparison the same questionnaire was sent out to a number of small hospitals with a bed capacity of from 40-50 beds. The following data has been furnished this Department by 42 large general hospitals, and 13 small hospitals.

A — PSYCHIATRIC PATIENTS

	Large General Hospitals	Small General Hospitals
1. *Isolation in General Hospitals*		
Special Psychiatric Ward	5	
Special or private room		
Under attendants or nurses	10	7
Under care of relatives	2	..
Under police protection	2	..
Attendants not mentioned	13	2
End room off public ward	2	..
Special detention ward	1	..
Steel wire cage over bed	1	..
"Best we can" without special accommodation	2	2
	38	11
2. *Removal of Patient*		
To mental hospital	2	2
To mental hospital or to relatives	1	..
All sent to City Hospital	1	..
	4	2
Total	42	13

B — ACUTE ALCOHOLICS

	Large General Hospitals		Small General Hospitals	
	Pay	Non-pay	Pay	Non-pay
Special Room (Special Nurse)	21	..	6	..
Special Room	..	7	..	6
Not Admitted	5	10	2	4
Isolation Ward	6	9	1	1
Police guard	..	4	..	1
Admitted only for other conditions	4	7	1	1
Admitted, but no special room	2	2	..	1
Psychiatric ward	2	4	..	..
Steel cage	..	1	..	..
Friends must stay	1	4	..	1
Male attendant or guard	..	..	1	2

(A large number of hospitals listed above as admitting alcoholics state that they endeavor to avoid doing so).

C — ATTEMPTED SUICIDES

Isolation in General Hospital	Large Hospital	Small Hospital
Special room	12	5
Psychiatric ward	3	..
No special accommodation	2	1
Observation ward	1	..
Room off public ward	1	..
Protection		
No experience	..	1
Police available	31	10
Police protection not asked	5	1
Guards	3	..
Private nurse	2	..
Trained nurse or relative	1	1
Total	42	13

Comments

It would appear that where patients on the public ward are diagnosed as mentally deranged, the most prevalent procedure where no special wards are available, is to isolate the patient in a private room as far away from the other patients as possible, or a specially protected room, where they will disturb the other patients as little as possible. Sedatives are used in most cases, if necessary, and patients are guarded either by special nurses or attendants. In some instances the hospital has to assume the cost of these special nurses or guards if patients are unable to pay, but this is a protection also for the hospital. Some hospitals have experienced poor co-operation from psychopathic authorities and in one or two instances have had to swear out a warrant that the patient was dangerous in which case the patient would be removed by the police to a psychiatric hospital. The administrator suggests that government provision might be made for all such cases at one of the larger hospitals where special wards and attendants would be available, as he does not consider it quite right to ask general hospitals, especially smaller hospitals, to look after these patients to the detriment of other patients in the hospital. Another solution offered is that adequate reception space be provided in psychopathic hospitals without the necessity for commitment, and segregation and soundproof rooms with the employment of trained personnel where psychopathic facilities are not available.

Another hospital superintendent asks friends to guard the patient, if the patient cannot pay the cost of guards, states they have to keep as close a watch on the guards as they do on the patients. Another superintendent finds that guards are not satisfactory, trained personnel being desirable. Another opinion was that "The wisdom of Solomon would not suffice for superintendents to deal with this problem. . . . health authorities should stress sterilization for the feebleminded, public hospitals are now filled to capacity and compelled

(*Continued on page* 48)

Obiter Dicta

Facing the Second Year of War

HOSPITALS in Canada and the professions associated with them have now completed one year of experience under war conditions. True, this war has not placed our hospitals under the local strain as has been the case in Great Britain or, with more tragic consequences, the hospitals in Poland or France; nevertheless our hospitals have experienced many added difficulties and none of the compensations noted in some of the industries.

Prices have gone up. For a few weeks after the war there was considerable inflation, particularly in certain drugs. Now prices are more stabilized, thanks in large degree to the prompt action taken at Ottawa. Nevertheless, the average price index of consumers' goods for the past year (July figures) has risen approximately 13 per cent. At that it is but 83.4 per cent of what it was in 1926. Of course, parts for German made equipment have been exceedingly difficult to obtain, if at all, and the added charges on non-British importations have added considerably to the cost of many articles.

Enlistments have affected the smooth operation of many hospitals very considerably. It has not been easy to replace highly trained nurses in key positions, radiologists, pathologists, technicians and others. In some instances especially needed individuals have been released to resume their civilian work. Fortunately, the situation has not been quite so serious as in the last war, for fewer men and nurses have been accepted so far for active service. Intern ranks have not been depleted to a great extent, due to the widespread feeling that the internship should be completed before entering the army. In all probability there will be more disruptment this coming year, albeit of a temporary nature, by the compulsory thirty day period of training to be undertaken by all single men of military age.

In coastal areas hospitals have had to make arrangements for eventualities in case of aerial or naval attack. Plans have been carefully worked out by a number of our hospitals for effecting blackouts, for emergency lighting and power, for evacuating patients and for the care of raid victims.

Legislation has not affected our hospitals as seriously as might have been the case. Fortunately the sales tax exemption has been retained and the hospitals will not now come under the unemployment insurance plan. The collection of the special 2 per cent income tax at the source has meant further bookkeeping. In some provinces there has been a noticeable tendency for overtaxed municipalities and for the provinces to tighten up on the grants provided for the care of patients. New and more uniform contracts have been developed for the care of C.E.F. and C.A.S.F. patients. In at least one case (Ontario Hospital, St. Thomas) a large mental hospital was entirely taken over for military purposes. The co-operation of the hospitals in the X-raying of recruits, and the recent assitance given by the staffs of several hospitals in examining evacuee children have been of tremendous assistance.

Of utmost concern to the hospitals has been the obvious deflection of both funds and personal interest from their support to that of special wartime activities. Although this could but be expected, it is a serious matter, nevertheless, for civilian hospital service must go on. Fortunately unnumbered friends of our hospitals are continuing their loyal support with unabated vigour. Although feeling the pinch our hospitals are, almost without exception, carrying on as usual and are facing the future with confidence.

Award for Meritorious Service well Placed

LAST year the Board of Trustees of the American Hospital Association set up an "Award for Meritorious Service" to be conferred from time to time upon that individual whose contribution to the furtherance of hospital development and service would be most outstanding. In conferring this award it was established as a policy that not only the current service being given, but the background of contribution over the years should be taken into consideration.

The unanimous choice of the Committee on Award of Merit for 1940 is Dr. Sigismund S. Goldwater of New York City. This selection will meet with widespread approval, for no person in the hospital field commands greater respect than does Dr. Goldwater. For more than forty years, Dr. Goldwater has been recognized as one of America's greatest hospital leaders. Not only did he make Mount Sinai Hospital one of the most efficiently operated institutions on the continent, but he was in constant demand all over the United States and Canada as a hospital consultant; many of the finest institutions in both countries are mute but telling evidence of his skill as a designer and organizer.

Dr. Goldwater has long been an exceedingly active worker in the American Hospital Association. Thirty-two years ago, when the Association met in Toronto in 1908, Dr. Goldwater was its president with the well remembered public spirited citizen, J. Ross Robertson,

as his first vice-president. Since that time Dr. Goldwater has maintained constant activity in the Association, serving on its most difficult and important committees almost without break. He was responsible for the linking up of the multitudinous committees under one Council on Community Relations and Administrative Practice, later amplified into seven councils. He was its first chairman. At an age when most individuals are seeking to lighten their daily load, Dr. Goldwater undertook one of the most arduous tasks imaginable, when he accepted the appointment as Commissioner of Hospitals in the City of New York and undertook to completely reorganize the hospital system of that city. As was to be expected, he met formidable opposition from many quarters, but he relentlessly and unswervingly pursued his mapped out course of action until his great objective had been achieved. One of the founders of the International Hospital Association and host to its first congress in 1929, Dr. Goldwater is known throughout the world. It is most fitting indeed that the first two recipients of this much to be coveted Award for Meritorious Service should be Malcolm T. MacEachern and Sigismund S. Goldwater.

The Ultimate Future of the Human Race

AT a time when Germany is doing everything in its power to utterly destroy every last vestige of Christian civilization—and is making all too effective headway in that direction—it is difficult to project one's thought beyond the immediate struggle and focus on the distant destiny of the human race, a period when Hitler, like Nero and Tammerlane, will have become a misty, half-legendary villain of ancient history. Will the human race evolve to new heights? Will it be swept from the earth by a still higher form of life a billion years hence?

We do know that the races are steadily mingling. Pseudo-scientific German statements to the contrary, there are few Europeans and fewer in America who are of unmixed racial stock. Modern transportation and current migrations will further homogenize the human race. Eugenics is still too young a science and too many unscientific assertions both for and against it have been uttered to properly estimate its value. Granted the need of some control in certain types of hereditary weakness, the greatest results will probably come from *positive* eugenics, the stimulation of greater fertility and more logical selection among the better elements in society. To quote Conklin, "If the heredity of the race is to be improved dysgenic social customs must be changed and a premium put upon the reproduction of the most fit. . . . Whatever is accomplished in the way of eugenics or euthenics must be through intelligence, education and social co-operation and, of these three factors, education is the one that can be most readily controlled. Education in the broadest sense is the chief hope of human progress".

Human biologists assure us that there is little probability that the human race will disappear. As hybridization proceeds, new types may appear, but already man has such control over his environment that to a large extent he controls his own destiny. Epidemics and insect invasions are not likely to wipe out the race entirely. Changes in climate, the return of an ice age, the sinking of a portion of a continent, or the formation of a desert might cause extensive migrations, but that would be all, for "man is able to control his environment rather than permit it to control him". To a large extent the future of the race depends upon man himself. Man's evolution in the past has been almost entirely the result of blind groping and unco-ordinated action. In its earlier stages "survival of the fittest" played the major role. While that principle still prevails nationally, it is far from operative any more for the individual; in fact, social science has tended to undermine the race in one respect by providing a sheltered environment for the physically and mentally weak. Evolution of the race to higher types in the future will depend largely upon intelligent and co-ordinated action by the peoples of the world and will depend upon the willingness of the individual to consider racial as well as personal interests and welfare. This implies a more widespread and sound conception of human biological objectives than prevails in the world at the present time.

The Memorial to David A. Stewart

IT will be very pleasing indeed to the many friends of the late Dr. David A. Stewart, for many years head of the Ninette Sanatorium in Manitoba, that his memory has been honoured by the erection of a cairn and tablet near the institution which he loved so well.

Dr. Stewart, whose death a few years ago was a great loss to the medical and hospital work of Canada, was one of the most remarkable men in the medical profession. Not only was he an outstanding authority on the care of tuberculosis, but he also achieved distinction in many other fields. He was widely known as an amateur geologist and naturalist. He was generally recognized as one of the most cultured members of the profession and his facile and versatile pen had few equals. He was greatly in demand, too, as a public speaker.

Although hampered by ill health for many years, his boundless energy led him to make every minute count. The Editor vividly recalls one delightful trip to Vancouver with Doctor Stewart. Going through the mountains there were several short delays. On every possible occasion he was quickly over the observation car railing and would shortly scramble back with new flowers to identify. Between courses in the diner he wrote bits of verse. Earlier on a trip to Prince Edward Island by a slow coasting steamer from Montreal, we recall that he made a detailed study of the diets followed in the fishing villages, basing his observations on the village gardens, the store shelves and the produce left at each stop by the steamer. His report of the International Tuberculosis Congress at Rome and the trip over, privately printed, is greatly treasured by those favoured with a copy. Later, when he became bedridden again for extensive periods, he took up dry point etching as something which could be done while lying on his back. In this he became remarkably proficient as his Christmas cards gave ample evidence, his great regret being that he had not discovered this additional talent thirty years earlier. It is fitting indeed that the memory of such a brilliant man should be so commemorated.

Problems of Smaller Hospitals

As Seen by a Special O.M.A. Committee

A SPECIAL committee of the Ontario Medical Association submitted a report on the problems of the staffs of smaller hospitals at its annual meeting in June. This committee was selected from the staffs of small western Ontario hospitals — R. P. I. Dougall, Petrolia (Chairman); M. D. Fletcher, Strathroy; D. G. Leatherdale, Tillsonburg; and W. C. Sproat of Seaforth (now of Stratford). The study was based on information submitted by thirty-one hospitals of *less than fifty* beds capacity, most of the replies coming from secretaries of boards or superintendents.

Equipment. On the whole this was satisfactory. Practically 100 per cent have X-ray facilities (there is no mention of the oversight), 40 per cent have fracture tables, 33 per cent have adequate splints and in 67 per cent the bed accommodation is satisfactory.

Salaries. Here there is considerable variation. In Northern Ontario salaries are generally higher.

	Monthly	*Average*
Superintendent	$100.00-150.00	$115.00
Assistant Superintendent	85.00-60.00	70.00
Night Supervisor	75.00-50	63.00
Day Supervisor	65.00-45.00	60.00
Night Nurses	90.00-45.00	55.00
Day Nurses	75.00-25.00	54.00

Dietitians. Only 20 per cent of the reporting hospitals have qualified dietitians. The average salary is $50.00 per month (presumably with board and maintenance—Ed.) The employment of qualified dietitians is recommended.

Nursing Service. Opinion is about equally divided as to whether substitution of graduate nurses for training schools has improved the standard of nursing service. Apparently in some hospitals low salaries for graduates has lowered the standard of service. The question is asked: Has the discouragement of t r a i n i n g schools in smaller hospitals fostered the development of u n a p p r o v e d schools, and if so, what effect will this tendency have upon the standard of nursing service in the districts concerned? It is recommended that the formation or continuation of unapproved training schools for nurses be discouraged. With respect to the extraordinary clinical activities of nurses, the Committee does not take the same viewpoint as does the Canadian Hospital Council as it recommends that these activities be restricted to the taking of blood pressures, blood counts and x-ray work.

Medical Staff. One-third of the hospitals reporting have no organized staff and in half of this group no supervision is exercised to protect the patient or the hospital. It is recommended that steps be taken to ensure either enforcement or revision with enforcement of existing regulations governing staffs of smaller hospitals.

In two-thirds of the hospitals, the doctors attend their own staff patients exclusively. In rural areas this means high mileage costs and is a burden upon the doctor.

The estimated value of staff services in one year in fifteen of these hospitals (on O. M. A. tariff basis) is $92,-725. The estimated value of the free service rendered by the average staff doctor in the hospital is placed at $760 per annum. This varied from a low of $53 to a high of $4,758 (3 doctors in a 30-bed Northern Ontario hospital).

Payment of Staff Doctors. All but two replies favoured payment of doctors for staff services on a 50 per cent basis. Of these one considered 25 per cent and the other 100 per cent of the O.M.A. tariff to be fair. The majority favoured joint payment by the municipality and the province. It is urged that "inasmuch as educational and other benefits associated with staff work in larger hospitals are lacking in small institutions; and as the absence of interns in the latter reduces the work of the staff man to the level of drudgery, and lack of equipment and expert advice, render him more vulnerable to legal action; and since legal responsibility can obviously rest upon no other shoulders action to secure remuneration for staff services in smaller hospitals be initiated."

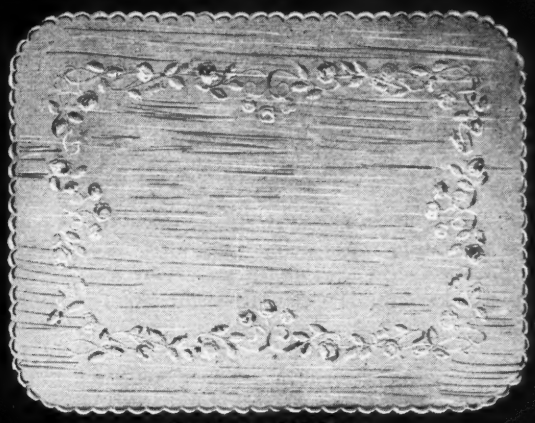
Admission of Staff Patients. This should be the responsibility of a permanently appointed non-political official, preferably the clerk of the municipality. Staff cases should be treated only by members of the organized staff.

Co-operation with the Trustees. It is recommended that "members of the medical staffs strive to develop closer co-operation with hospital boards to the end that improved conditions with respect to equipment, records, nursing service, and a higher standard of medical service may result."

Employment of Aliens in English Hospitals

In order to clarify the situation as regards the employment of aliens, particularly nurses, in hospitals, the British Ministry of Health has issued a new circular dealing with the employment of aliens in hospitals. No person of German, Austrian or Italian nationality may be employed on the paid or voluntary staff of any hospital providing treatment for members of His Majesty's forces, but they may be retained in hospitals not providing treatment to Service cases. The services of persons of Czech nationality may be retained even at hospitals providing treatment for Service cases, *if* they obtain a permit from the Aliens' War Service Department. Exceptionally, enemy aliens holding British medical or dental certificates may be retained in hospitals receiving Service cases *on special permission being obtained.*

The regulations do not apply to persons formerly of German, Austrian or Italian nationality but now not of these nationalities, whether by virtue of naturalization or marriage. Other aliens can be employed in a hospital providing treatment for members of His Majesty's Forces, subject to permission being obtained from the Aliens' War Service Department.



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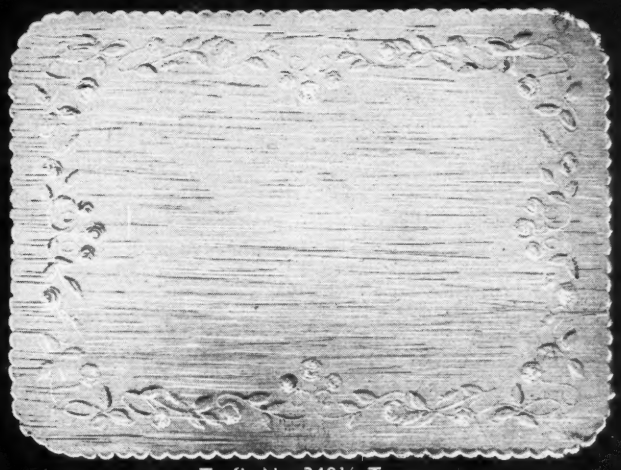

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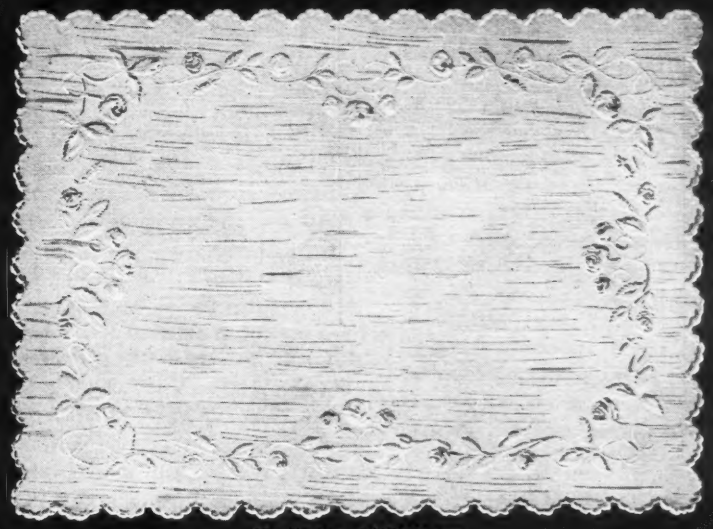

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Graduate Medical Training in the Hospital

Commission Makes Valuable Recommendations

THE Commission on Graduate Medical Education, set up by the Advisory Board for Medical specialties in 1937, has published a very valuable report on the internship, the residency and other forms of graduate medical education. This Commission is made up of twenty of the outstanding educators in the United States, the chairman being Dr. Willard C. Rappleye, Dean of Medicine at Columbia, and with Dr. Robin C. Buerki of Madison and Chicago as Director of Study. While based primarly upon a survey of graduate education in the United States, the observations and recommendations are definitely applicable to our Canadian situation and of interest to our hospitals with interns or residents.

Internship

It is emphasized that the internship should be fundamentally the same whether as a preparation for general practice or for further training in a specialty. Although agreeing that the present one year internship (as conducted in most approved hospitals) should prove adequate if properly integrated with clinical clerkships, the Commission hopes to see longer internships developed to more properly prepare for general practice. The internship does not qualify one to practise as a specialist.

The internship should be a responsibility not only of the hospital but of the medical school as well. There should be an affiliation of the hospital with a medical school although without any implication of financial or administrative control. "Whether medical schools desire to withhold the degree until the completion of the internship is not vital; the important thing is an appreciation of the internship as a part of the basic preparation of the physician." Greater co-operation is urged.

Educational Director

The suggestion is made that the hospital might appoint a physician as "educational director" on a full time or part time basis. The many ways in which he could improve the educational aspect of the internship are considered. This suggestion was advanced some time ago by Dr. E. S. Ryerson (See Canadian Hospital, February 1939.)

Many admirable recommendations are made. Outpatient training and experience are urged. Special attention should be given to chronic diseases. To give the interns interest in laboratory procedures a practical focus, he should do laboratory work on his own patients rather than do routine laboratory work for a specified period for patients with whom he has no contact. Functional disorders should receive special study. On the surgical service he should be taught surgical diagnosis, preoperative and postoperative care and the treatment of emergencies. "Interns should be taught only those surgical technics that every general practitioner should know. The technics of operative surgery should be taught only to a resident."

The case load per intern should not be made too heavy. (This is a mistake frequently encountered, although difficult to overcome in view of the shortage of interns). It is recommended that each intern or resident have not more than eight to twelve patients (public) at one time.

Limited Rotation

The Commission does not like the common practice of giving the intern a smattering of all special fields by rapid rotation on different services. Due to the increasing number of highly trained specialists, the viewpoint is expressed that "the intern's time should be concentrated in the relatively few fields that will constitute the great bulk, if not the entirety, of his general practice, or will give him a proper background for training in a specialty. These fields are general medicine, pediatrics, surgical diagnosis, minor surgery and first aid in emergencies, and normal obstetrics". Apparently dermatology, gynecology, abnormal obstetrics, venereal diseases and ophthalmolgical and otolaryngological conditions would not be taken up, except as encountered in the outpatient department. While this may be a recognition of present day practice in many large cities, it is questionable if this would be an adequate internship for general practice in smaller centres or in rural communities.

"Hospitals that cannot make adequate educational opportunities available for interns or residents should seriously consider employing as salaried house officers young physicians who have completed their internships."

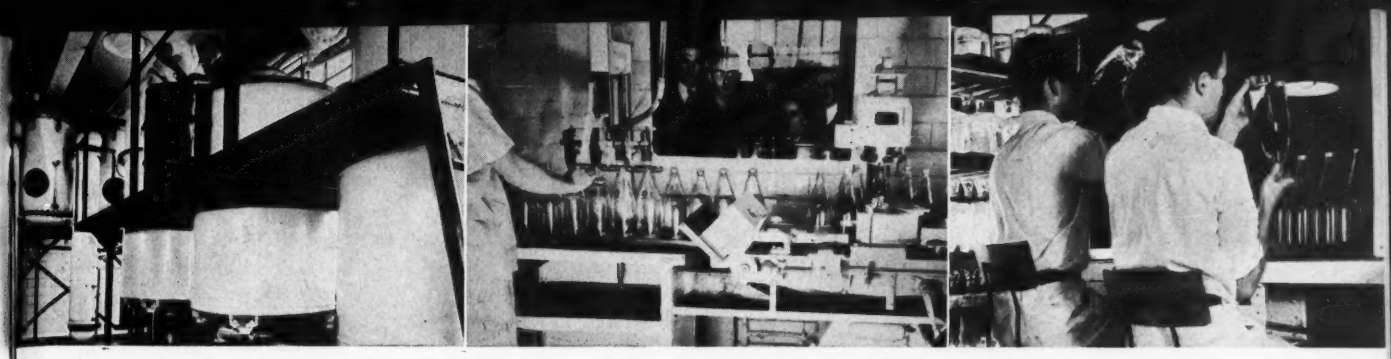
Residency

Since 1930 residencies have increased from 2,028 to 4,556. In the last five years, residencies of three years or more have increased from 332 to 1,791 — over 500 per cent increase. The stiffer requirements of the specialty boards have increased the demand for these longer, more highly developed, residencies and older doctors are finding it difficult to obtain these appointments.

It is recognized that three years of special training, in addition to the internship, is now necessary for nearly all specialties. The hospital should not accept more first year residents than it can carry on to the third year. Hospitals should not accept residents unless equipped to offer educational opportunities of university caliber. Here too university affiliation is advised. Considerable onus rests on the chief and his associates to give the resident adequate training.

"The residency should provide preparation in the sciences basic to the specialty as well as sufficient clinical experience, under supervision, to ensure real competence." As few hospitals can offer study in the basic sciences, the medical schools are

(*Continued on page* 48)



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American Hospital Association Holds Forty-Second Convention in Boston, September 16—20

BOSTON, one of the most interesting cities of the United States from a historic viewpoint and a famous medical centre, will be the focus of interest for hospital workers of this continent when the American Hospital Association holds its 42nd annual convention there September 16-20. Meeting concurrently with the Association are the American Protestant Hospital Association, the American College of Hospital Administrators, the American Association of Occupational Therapy and the American Association of Nurse Anesthetists. Headquarters for the American Hospital Association will be the Statler Hotel.

The combined programme of the associations offers more than fifty sessions. The sessions of the American Hospital Association programme alone cover nursing, pharmacy, social service, out-patient, tuberculosis, group hospitalization, governmental hospitals, public relations, dietetics, trustees, women's auxiliaries, administration, construction, mechanical, small hospitals, children's hospitals, and intern and residency. The third annual meeting of the House of Delegates will bring to the members of the Association reports of more than fifty councils and committees of the American Hospital Association. Educational exhibits and the technical exposition are, of course, unequalled, and the hospitals of Boston will be open to delegates for practical demonstrations.

The session on hospital service plans will be of particular interest. Dr. Rufus Rorem will speak on "Recent Developments in Hospital Service Plans" and Dr. S. S. Goldwater, another outstanding authority on this subject, will deal with "Next Steps in Hospital Service Plans". The Round Table on Hospital Service Plans later in the week will feature a panel discussion on the inter-dependence of hospitals and hospital service plans to be participated in by hospital superintendents and by the directors of some of the largest plans in the country.

One of the most interesting questions of the day in dietetics, "Are Special Diets Overdone?" will be discussed by Mary Ruth Curfman, B. S., M.A., Supervising dietitian of St. Luke's Hospital, New York.

Ruth C. Wilson, Secretary of the New Brunswick Hospital Association, will give the Canadian view of "The Out-patient Problem in the Small Town". Raymond P. Sloan, editor of *Modern Hospital,* will preside over the Trustee section at which different speakers will deal with the relationship between the hospital administrator and the trustee. Mr. Oliver Pratt, superintendent of the Salem Hospital, Mass., will speak on "How to Achieve the Ideal Hospital Board". Edward F. Stevens, well known hospital consultant of Boston will give a paper on "Modern Trends in Hospital Construction".

The rural hospital programme in the United States will be discussed by Graham L. Davies, Consultant, W. K. Kellogg Foundation, Battle Creek, and Claude W. Munger, New York City. Dr. Harvey Agnew, Toronto, will speak on the Canadian programme of hospital public relations. Under Governmental Hospitals, James A. Hamilton, Director of the New Haven Hospital, Connecticut, will speak on Public Hospital Organization and Control. Miss Marjorie Buck, superintendent of the Norfolk General Hospital, will act as secretary of the Small Hospital Section, at which papers on nursing service and credits and collection will be presented and discussed at a round table.

One of the new features of the programme is the section on intern and residency. Among the papers to be given is that by Dr. Willard C. Rappleye, Dean of Columbia University College of Physicians and Surgeons, who will speak on "General Principles of an Educational Programme for Intern and Residents".

Mrs. O. W. Rhynas, president of the Women's Hospital Aids Association of Ontario, will take part in the round table on women's auxiliaries. Her paper is entitled "Hospital Aid Committee".

Canadian Provincial representatives in the House of Delegates include the following: A. K. Haywood, M.D., J. H. McVety (alt.); A. F. Anderson, M.D., Rev. Sister Mary Beatrice, R.N. (alt.); C. C. Gibson, Leonard P. Goudy (alt.); G. S. Williams, M.D., Kathryn M. McLearn, R.N. (alt.); A. J. Swanson, R. Fraser Armstrong (alt.); W. H. Delaney, M.D., C. A. Decary, M.D., (alt.); S. R. D. Hewitt, M. B., A. J. MacMaster, R.N., (alt.); and E. P. Graham, R.N., and George A. MacIntosh, M. D., (Alta.); and Dr. Harvey Agnew, of Toronto, ex officio as A.H.A. Past President.

The full programmes of the American Hospital Association, the American Association of Occupational Therapy and the American Association of Nurse Anesthetists are published in the August issue of *Hospitals.* The September issue will carry the programmes of the American Protestant Hospital Association and the Convocation of the American College of Hospital Administrators.

Hospital Care Plan Claims Record Low for Administration Costs

The Cleveland Hospital Service Association believes that its operating costs of 9.03 per cent of earned income, as calculated for the six-month period ending December 31st, 1939, is the record low for hospital plans in the United States. The plan was begun in 1935 and, due to the expenses of educational and promotional work, the operating cost for the six-month period ending June 30th, 1935, was 29.74 per cent. One year later administrative costs had dropped to 15.99 per cent, and steady decrease throughout the five years has finally brought the figure down to its present proportions. This plan has over 300,000 subscribers.

Every 22 minutes a subscriber under the Michigan Hospital Service group hospitalization plan is admitted to a hospital in Michigan.

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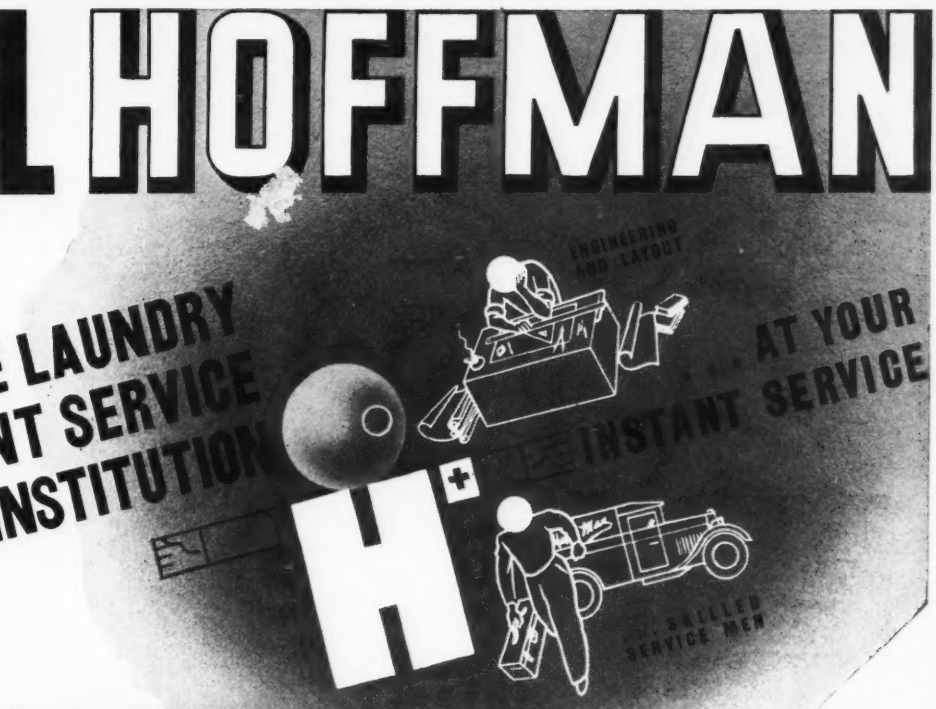

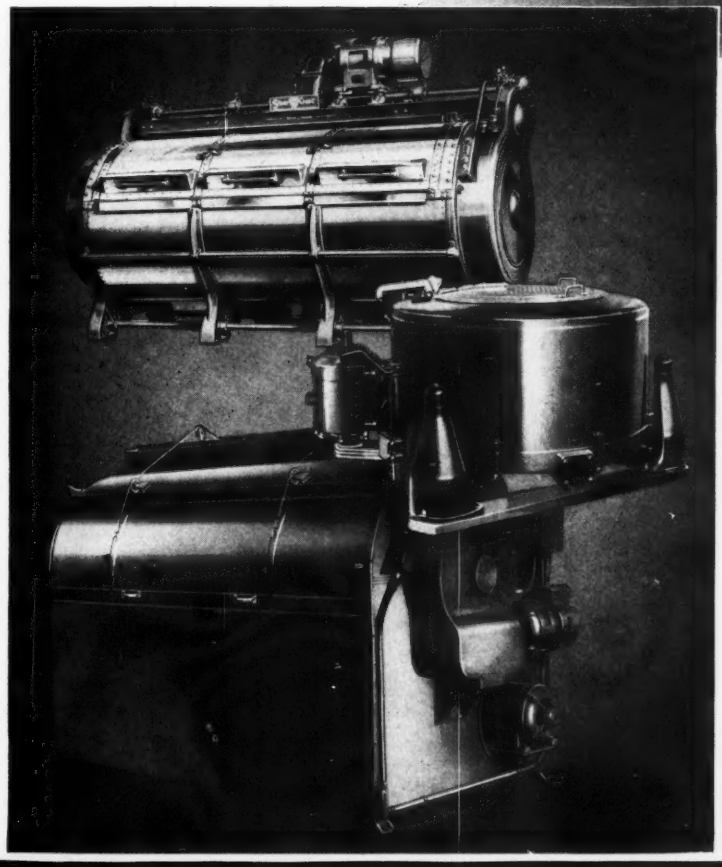

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American College of Hospital Administrators Meets In Boston, September 14—16

The American College of Hospital Administrators is holding its annual meeting in Boston September 14th to 16th during the convention of the American Hospital Association. The convocation, which is the outstanding feature of the meeting will be held at 3.00 p.m., Sunday, September 15th, in the ballroom of the Hotel Statler, headquarters of the meeting. Dr. Fredrick A. Washburn, Hartford, Conn., will be the convocation speaker, and the president of Yale University, Mr. Charles Seymour, will be the guest speaker at the banquet that evening.

Among those being inducted directly to Fellowship is Rev. Mother Marie Rose Audet, superintendent of the Hotel Dieu de St. Joseph, Campbellton, New Brunswick and Mr. Wm. H. Harper, House Governor of the Royal Hospital, Wolverhampton, England. Miss Helen Potts, Superintendent of the Woodstock General Hospital, Ontario, is being advanced to fellowship. Canadian members being inducted include A. J. Chopin, Superintendent of St. Mary's Hospital, Montreal, Que.; Rev. Sister Marie de la Ferre, Superintendent, Hotel Dieu of St. Joseph, Windsor, Ont.; and Rev. Sister Mary Theodore, Superintendent of St. Joseph's Hospital, London, Ont. A former Canadian, A. E. Norton, now assistant superintendent of the New Rochelle Hospital, N.Y., is also being received as a member. Associate members include the following Canadians: Miss Edith Amas, director of nursing, Saskatoon City Hospital, and Rev. Sister Mary Loretto, assistant superintendent, St. Joseph's Hospital, London, Ont.

The general educational session scheduled for Monday morning will be of interest to all administrators. Among the speakers will be Dr. M. T. MacEachern, Mr. Alden B. Mills and Mr. Gerhard Hartman.

American Protestant Hospital Association Meets September 13-15

The American Protestant Hospital Association will meet in Boston, September 13-15, just prior to the week of the A.H.A. convention. Headquarters for the meeting will be the Copley Plaza Hotel. The theme of the convention this year is "At work with the Master Physician in the Protestant Hospital". A most interesting programme has been prepared, which includes as speakers some of the outstanding hospital authorities on the continent.

SCHEDULE FOR PURCHASING

(Cleveland Hospital Council)

Classification	Minimum Supply	Maximum Supply
Stationery	3 mos.	6 mos.
Printing	6 mos.	1 year
Laundry and housekeeping supplies	2 mos.	3 mos.
Clothing, bedding, etc.	3 mos.	6 mos.
Electric bulbs	1 case lot	Case lots
Dietary supplies:		
Staples	3 mos.	6 mos.
Perishables	Daily	3 days
Canned goods (fut.)	6 mos.	9 mos.
Gauze and cotton	1 mon.	3 mos.
Ether	1 wk.	1 mon.
Laboratory supplies	2 wks.	4 mos.
X-ray films	1 wk.	6 wks.

Booklet on Job Specifications Published by A.H.A.

The application of job specifications is a necessary condition for the achievement of stability of the working force, satisfactory rating of the employees, and a consistent plan of compensation and promotion of employees. These are most important for maximum efficiency of organization according to a booklet on "Job Specifications for a Hospital Organization" which has just been published by the American Hospital Association. The booklet, Bulletin No. 202 of the Personnel Management in Hospital Series, was prepared by a sub-committee of the Committee on Personnel Relations, consisting of Mr. James Stephan, (chairman), Miss Nellie Gorgas, and Dr. Gordon Meade. The first sections of the book are concerned with the definition of a job specification, the need for job specifications, their use and their application by the individual hospital. The latter part of the bulletin lists job specifications for hospital positions.

Each specification is divided into three statements: duties included in the job; examples or typical tasks to be performed; and the minimum qualifications required. The material presented is based upon information obtained from a survey of the existing organization of several hospitals. A final part of the manual has been given over to descriptions of combination positions which are found in 2 actual small hospital organizations, one a 60 and the other a 75-bed hospital.

The material presented in this study was not meant to be all-inclusive, but is intended rather to merely indicate the fundamental duties, responsibilities and qualifications of employees in each position.

Fine bits of broken glass which defy the broom may easily be picked up with moistened absorbent cotton.

— *Capper's Farmer.*

Border Regulations Do Not Prevent Canadians From Attending Meetings in U.S.

Contrary to common opinion it is not difficult for Canadians to make arrangements to attend conventions or administration institutes in the United States. Many Canadians are desirous of attending the convention of the American Hospital Association in Boston in September and the hospitalization conference of the American College of Surgeons in Chicago in October. It is only necessary that certain stipulated procedures be followed. In addition to the obtaining of a passport, it is necessary to have a consular visa which can be obtained from the nearest American consulate. For this additional passport, photographs are necessary. These should be small, on a light background if possible, should bear the signature of the applicant, and one at least should be certified on the back as a correct likeness by a citizen in some responsible position. In addition it is necessary to have letters of identification. Full details of the requirements could be obtained from the nearest consulate. In view of the fact that it takes some time to arrange an appointment and that sometimes further revisions must be made in the papers submitted, these arrangements should be made at the earliest possible moment.

As for money, individuals are permitted to obtain up to one hundred dollars (in addition to transportation purchased in Canada) by making application at one's bank. The Foreign Exchange Board permits banks to release funds up to this amount when individuals are going to the United States on business, for educational purposes, for health, or in cases of special emergency. Attendance at a hospital convention or a refresher course in administration would come under the heading of educational purposes and, in the case of members of the House of Delegates, etc., could be considered as business. While the bank manager may feel free to issue the funds forthwith, again it would be advisable to make application early so that the application could be submitted through bank channels to the Foreign Exchange Board. This year the Canadian delegation to these conventions will not be graced with the presence of the wives of delegates, as the banks are not authorized to provide funds for other than the individual going on business or for educational purposes.

Lessons From a Bombed Hospital

"The following extracts from a report issued (as we go to press) by the British Hospitals Association indicate some of the conclusions to be drawn from actual experience of air raid damage to a hospital.

"Six bombs were dropped in the hospital ground in a recent air raid. Three bombs fell close together on a corridor leading from the main building to the ophthalmic wing. One small bomb was dropped on a tennis court and one large bomb fell on the end of the nurses' home. Fortunately nobody was injured. The nurses' home was unoccupied at the time, but the ophthalmic wing was full of patients.

"The three bombs which hit the passage burst the steam pipes in the basement corridor which normally would be used as a shelter. As no air raid warning had been given, the corridor was empty. Clouds of steam were given off and it was at first thought that incendiary bombs had been dropped. The passage became flooded to a depth of several feet. The lessons to be learned from this experience are:

(1) That basements and passages with water or steam pipes running through them should not be used as shelters if it can be avoided.

(2) That it is advisable that several people on the premises should know where the main cocks can be turned off so that any one of them can act with a minimum of delay.

"The heavy bomb which fell on the nurses' home pierced right through the roof, a reinforced concrete floor and a 6 in. brick floor, apparently exploding on the last, heavy masonry falling through into the basement. The conclusion to be drawn is that with a bomb of this size there can be no protection from a direct hit.

"The effect of the blast was a little surprising. Masonry, doors and window frames were blown considerable distances, but comparatively little glass was broken. Even windows within a few feet of the explosions were in some cases undamaged."

—*The Hospital* (London) August, 1940.

The Hospitalization of Soldiers

It would appear that the procedures to be followed in the hospitalization of C.A.S.F. patients and in the rendering of accounts for this service is not clearly understood by all hospital administrators. Apparently it is not clearly understood which patients still remain under the Department of Defence and which have been turned over to the Department of Pensions and National Health for treatment. On advice from Ottawa it is recommended that if any superintendent has any trouble whatsoever over the admission of C.A.S.F. patients or payment for expenses incurred on behalf of such patients, the superintendent should at once get in touch with the District Chief Medical Officer of the Department of Pensions and National Health for further instructions.

Manitoba Hospital Service Association Covers 32,722

The Manitoba Hospital Service Association, which began operating in January, 1939, has issued a statement which covers membership and financial status up to the end of June. The plan now numbers 14,936 subscribers, and 17,786 dependents. Under the contract enforced dependents receive one-half coverage. At the end of the first financial year it was felt the strong financial position justified an increase in benefits and accordingly benefits for those entering their second year membership were increased from 21 to 28 days of hospitalization. The total of reserves and surplus now approximates 2 months hospitalization.

Strathroy Superintendent Resigns

Mrs. Nellie Malone, superintendent of the Strathroy Hospital, Ontario, for the past seven years, has resigned owing to ill health.

Here and There in the Hospital Field

By THE EDITOR

Broken Nose in Softball "Casualty" "Somewhere in England"

A FRIENDLY game of softball ended unfortunately for Col. E. A. McCusker, who is with the 1st Division "somewhere in England." Col. McCusker, a prominent eye, ear and nose specialist of Regina, was playing softball in a game between a team made up of headquarters staff of the 1st Canadian Division and the village cricket club. Dr. McCusker suffered a broken nose when a foul ball struck him while he had his mask off.

* * *

Woman's Part in the War

Nurses and military laundresses were the only exceptions made by the Government when ordering the evacuation of women and children from Hong Kong and Gibraltar.

Nursing Illustrated, an English journal for nurses, comments on the attractive appearance of the Canadian nurses at the opening of the Canadian Red Cross Hospital at Taplow. The editorial commentator said frankly: "We were struck by the amazing slimness of the staff and wondered what the secret is."

The first woman doctor to be given senior army rank is Dr. Anna Reaveley Glover, R.A.M.C., who has been promoted to the post of Deputy Assistant Director of Medical Services for the A.T.S. Eastern Command. Surgeon-Lieutenant Genevieve Rewcastle, R.N.V.R. is the first woman doctor to be given naval rank.

* * *

R. F. Armstrong Assumes Heavy Responsibility

The public relations of our hospital superintendents sometimes lead them into unusual tasks. Mr. R. Fraser Armstrong, superintendent of the Kingston General Hospital, has accepted the position of Campaign Director for the Kingston and Portsmouth War Savings Campaign. Already his well known organizing ability has resulted in the setting up of a very efficient type of campaign organization with ramifications extending throughout the entire area. In view of this leadership and the fact that the campaign is being organized upon a cumulative basis, we anticipate excellent results in the Kingston area.

* * *

Bronze Buffalo to Dr. Stephens

A bronze buffalo standing on a base of Manitoba marble was presented to Dr. George F. Stephens prior to his departure from Winnipeg at a dinner tendered to him by over one hundred of the trustees and doctors with whom he has been associated at the Winnipeg General Hospital. In making the presentation, Mr. Sellers stated, "Dr. Stephens has done a great job for the hospital and has been a great citizen". Dr. George S. Fahrni, President-elect of the Canadian Medical Association, presided. The Manitoba Hospital Association also tendered a luncheon to Dr. Stephens prior to his departure.

* * *

Canadian Army Doctors Entertained by Middlesex Hospital

The *Lancet* recently noted the hospitality extended to Canadian medical officers by the Middlesex hospital. The Canadian officers visited the hospital in groups of about 20, and the program planned for them was in the nature of a brief "refresher course". The Earl of Athlone appeared at the hospital one afternoon and took tea with the Canadian officers shortly before he left England for Canada.

* * *

A New Form of Public Service

St. Mary's Hospital at Timmins has extended its public relations into a unique field. Last week a provincial constable stopped a motor car near one of the gold mines in that district. Suspecting that the passengers might be highgraders, the constable slipped a tight elastic band around the bottom of the trouser legs of the men and took them to St. Mary's Hospital, where they were put under the screen by Dr. Norman Russell. The x-ray revealed metal capsules measuring about three inches in length by one and a half in diameter and containing high grade gold ore on the bodies of the men. The capsules and ore are being held by the police as exhibits for the forthcoming trial.

* * *

Miss Vera Dale Record Librarian at Fort William

Miss Vera E. Dale, who for a number of years was assistant to the Secretary of the Department of Hospital Service of the Canadian Medical Association at its Toronto office, has accepted the appointment as record librarian at McKellar Hospital, in her home town, Fort William. Trained primarily as a record librarian, Miss Dale has been Registrar of the Association of Medical Record Librarians of Ontario since its inception. Her many friends wish her every success in her new position.

Miss Marjorie Riddell of Toronto will assume her work with the Department of Hospital Service.

* * *

Mrs. Mary Shaw Joins Canadian Hospital Council Staff

Owing to the prolonged illness of Miss Anne MacLachlan, who for a number of years has been assistant to the Secretary of the Canadian Hospital Council, it has been necesary to make some rearrangements in the office staff. We are pleased to report that Mrs. Mary Shaw, widow of the late Mr. Leonard Shaw, former editor of this magazine and well known superintendent of the Saskatoon City Hospital, has been added to the staff of the Canadian Hospital Council. Prior to coming to Toronto in August, Mrs. Shaw was with Mr. John Mannix and Mr. Carl Flath in the Michigan Society for Group Hospitalization.

A Definition

A "minor disability" is a trivial complaint which people disregard when they must work for their living, but which becomes a "major" disability when they can get compensation, draw a pension, or go on insurance.

WOMEN'S HOSPITAL AIDS ASSOCIATION

Province of Ontario, Canada

Association formed 1910
Individual Aid formed 1865

Attention! All affiliated Hospital Auxiliary Groups! Keep the following dates free—October 9, 10 and 11—to attend the Annual Convention, which is held conjointly with the Ontario Hospital Association at the Royal York Hotel, Toronto. An executive meeting is to be held on the evening of October 8th at 7.30 o'clock. Presidents of all affiliated groups are members of the executive. A banquet has been arranged for the evening of October 9th in the Ballroom, Royal York Hotel.

Mrs. Matthews, wife of the Lieutenant-Governor, will be a guest and will extend greetings; also Doctor Malcolm MacEachern, Doctor F. W. Routley, Doctor G. Harvey Agnew and Mr. Alden B. Mills, Managing Editor, Modern Hospital Magazine.

October 9th will be devoted to reports and discussions. On the morning of October 10th in Convention Hall, Doctor Malcolm MacEachern will preside over a Round Table. It is expected that representatives from Rochester, Montreal and Ontario will participate in introducing subjects for discussion.

The Programme Committee are endeavouring to make this Convention of vital interest to everyone. Will you do your part by attending yourself and persuading others to do likewise? New hospital problems are a constant concern. Let us do our share in helping solve these problems.

We all need stimulation, admonishing and wise counselling. The times demand zealous and faithful workers. We need the exchange of thought and greetings with our fellow workers. Progress is made only by sincere individual effort. We all know that rugged individualism is still the greatest factor in human achievement — learning to do the right and wise thing at the right time. The happiest people in the world are the willing workers doing the useful, needful things and seeing definitely good results at the close of the day.

We must keep abreast with the demands of these serious days by developing our minds and abilities to do the right job at the right time. Only then can we expect to see a glorious new sunrise after a sombre night.

There are many who will wish to attend the banquet honouring our distinguished guests. Tickets are available and may be secured from Mrs G. W. Houston, 902 King St. E., Hamilton. You will be wise to get your tickets early.

Canadian Dietetic Association Officers 1940-41

Hon. Pres. Frances McNally; *Hon. Vice-Pres.* Ethel B. Rutter; *Pres.* Alice Stickwood; *Pres. Elect.* Grace Sharpe. *Board of Directors*: *Quebec,* Ruth Reid, Charlotte Large, Irene Carpenter. *Ontario,* Muriel Eames, Laura Pepper, Wilma Gear.

Councillors: *Maritimes*: Ruth Cook, Ellen H. Todd. *Manitoba*: Marjorie Dick, Mary Hiltz. *Saskatchewan*: Edith Needham, Grace Weatherilt. *Alberta*: Colena Nickell, Ruth Eager. *British Columbia*: Helen King, Ethel C. Pipes.

Check List of Hospital Insurance

FEW hospitals, if any, will require all of these coverages. This list should be the basis for a study of the borrower's premises by an experienced insurance man, who will then recommend the insurance needed. Many of these items are added to other policies as endorsements, and need not be separate policies.

Name of Insurance	Repays Losses Resulting From:
Accounts receivable	The lack of ability to collect amounts due to business because of the damage to or destruction of records by fire, lightning, and so on.
Aircraft property damage	Falling aircraft or objects falling from aircraft, causing damage to buildings, statuary, trees, shrubbery and the like.
Automobile fire, theft and collision	The damage or loss of the insured automobile by fire, theft or a collision.
Automobile non-ownership	Claims for bodily injury or damage to the property of others caused by the automobile of an employee used in the service of the insured.
Automobile operator's	Injury or death of a person or damage to the property of others caused by an automobile while the insured (or his employee) is driving the cars of others (such as parking the cars of hotel guests.)
Automobile public liability and property damage	The automobile of the insured causing injury, death, or damage to the property of others.
Boiler insurance	Loss, expense, and damage resulting from an accident to a steam boiler in which property damage or bodily injury to persons occur.
Burglary	Property being stolen by someone entering the building for the purpose of stealing, and leaving visible marks at the place of entrance.
Check alteration and forgery	The wrongful use of the insured's name on a check, or the changing of the check as to amount or payee after the insured wrote it.
Consequential fire	A burning of property other than that insured, which results in damage to the insured property.
Consequential loss of contents of refrigerators	Burning or exploding which makes the refrigerating equipment inoperative with a consequential loss of the contents of the refrigerator from spoilage.
Earthquake	A violent shaking or trembling of the earth which damages or destroys the insured property.
Electrical machinery	Damage to the property of the insured, damage to the property of others for which the insured is held liable, and the cost of litigation, all arising from accident to the electrical equipment.
Elevator liability with property damage endorsement	Injury or death of any person not employed by the insured; or damage to the property of others, held to have been caused by the named and described elevator of the insured.
Explosion legal liability	Damage to the property or the person of others resulting from an explosion on the property of the insured.
Fidelity bond	The dishonesty of employees of the insured.
Fine arts floater	Damage to, destruction of, or theft of described paintings, tapestries, rugs, sculpture, and other art objects.
Fire and explosion legal liability	Being held legally liable for loss to other property because of a fire or explosion in the insured property.
Forgery bond	Someone signing the names of the insured to checks, notes, or other documents in an attempt to obtain money or other property illegally.
Fire with additional hazards endorsement	Damage or destruction of the insured property by fire, windstorm, hail, riot, explosion, air craft, motor vehicle, smoke damage, or oil burner smudge.
Hired car public liability and property damage	Bodily injury or damage to the property of others caused by an automobile or truck hired for the use of the insured, but not owned by him.
Inherent explosion	Explosion caused by equipment or materials (gas, dust, and the like) which are regularly used in the business.
Inside holdup	Forcible possession of personal property being taken within the premises of the insured.
Malpractice	The insured being held liable for injury or death caused by an employee, such as physician, druggist, barber, or beautician, in the course of performing his work.
Messenger robbery	Forcible possession being taken of money, securities or goods (or an attempt to take) while in the custody of an employee outside the premises of the insured, during certain hours.
Outside holdup	Forcible possession being taken of personal property while it is in custody of an employee outside the premises of the insured.
Paymaster robbery	Forcible possession of money being taken from an employee who is distributing wages.
Permit bond	Infringement of a permit issued to the insured.
Plate glass	Breakage or other damage to plate glass, specifically described. The glass is usually replaced rather than a money payment being made.
Products liability	Claims for illness or death resulting from products such as food and drink manufactured or sold by the insured.
Public liability and property damage	Bodily injury, death, or damage to the property of others (not in the employ of the insured) for which the insured is held liable.
Safe burglary	Personal property being stolen from a vault or safe.
Safe deposit box	Forcible possession being taken of the contents of a safe deposit box named (usually with others) in the policy.
Workmen's compensation	Injuries to workmen for which a workman's compensation law requires the employer to pay.

—ARNOLD H. EMCH, Ph.D.,
Assistant Secretary, American Hospital Association,
in the Bankers Monthly.

Coming Conventions

Sept. 16-20—American Hospital Association, Boston, Mass.

Oct. 8-9—Ontario Conference of the Catholic Hospital Association, St. Michael's Hospital, Toronto.

October 8-9—Manitoba Hospital Association.

Oct. 9-11—Ontario Hospital Association, Royal York Hotel, Toronto.

October 11-12—Saskatchewan Hospital Association.

Oct. 15-17—British Columbia Hospitals Association.

October 20-24—American Dietetic Association, Pennsylvania Hotel, New York City.

Oct. 21-22—Alberta Hospital Association.

October 21-24—American College of Surgeons, Hospital Standardization Conference, Chicago.

Oct. 28-Nov. 9—Course in Hospital Administration for Nurses, School of Nursing, University of Toronto.

Major P. E. Reynolds Overseas

Major P. E. Reynolds, solicitor to the Saskatoon City Hospital, has been appointed second in command of the Saskatoon Light Infantry Battalion, M.G., now in England with the 1st Division of the C.A.S.F. Major Reynolds is known to the readers of this journal as the author of "Recent Decisions Affecting the Liability of Hospitals", which appeared in the March issue of THE CANADIAN HOSPITAL.

Army Hospital Unit Opened at Currie Barracks, Calgary

A 34-bed hospital has been completed at a cost of about $35,000 at Currie Barracks, Calgary, Alberta. The hospital is conducted by No. 13 Detachment, R.C.A.M.C. Lieut. Col. J. A. Reid district medical officer is in charge of the hospital and Lieut. William Dunlop, R.C.A.M.C. is in immediate command.

Planning the Morning Conference

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and, more recently, by "dagenan" are considered.

On the sixth day the nurse is impressed with her role as health teacher. To-day this position of hers in the community and hospital, even as a student nurse, cannot be stressed enough. If the nurse is tactful and pleasant there is no limit to what she can teach her patient in general rules of health. Particularly can she guide him through convalescence and even to some extent plan his life after discharge so as to gradually equip him for full activity, or at least for that activity which he will be able to undertake. By showing him the dangers on the road ahead, and how to circumvent them, she is making a valuable and useful contribution to the field of preventive medicine. How many an adult would be absent from our cardiac wards to-day if that individual had been taught that rheumatic fever, if not properly treated, leaves severe heart complications in its wake.

The seventh day is given over to a nurses' contest, conducted as a spelling match with two teams. The captains may ask any question on the week's study. This contest assures you of attention during the week, and adds to the spirit of competition.

This programme calls for a comprehensive knowledge of her work by the supervisor. Generally speaking, she should attend the doctor's lectures and know what the lecturer has taught. Perhaps she will have to enlarge on his teachings. Doctors are often prone, in their lectures, to give their personal ideas of treatment too dogmatically, leaving the pupils to believe that anyone using different treatment is in error. Too often the principle behind the treatment is forgotten; that is where our main work lies—to show that variations of treatment may bring the same result, if the principle be the same.

The morning conference also supplies a need in the schools where efficiency has to some extent made the purely "patient assignment" method practically impossible. The pupil nurse becomes more interested in her patient as an individual, and will surprise you in a very short time with the problems which she will solve for herself.

An address to the Prairie Provinces Conference, Catholic Hospital Association, Calgary, June 23-24, 1940.

Graduate Medical Training

(*Continued from page* 34)

needed to supplement the hospital facilities.

Post Graduate Courses

The importance of post graduate education for practising physicians is emphasized and the need for adequate courses—long and short—is reviewed. This is an excellent analysis, too, of post graduate facilities in Great Britain. A number of excellent refresher courses in the U.S.A. are reviewed. It is interesting to note, however, that none of these have been at all as extensive as the nation-wide tours of university and other authorities financed for many years through the Canadian Medical Association by the Sun Life Assurance Company of Canada.

Graduate Medical Education — Report of the Commission on Graduate Medical Education — 1940 — University of Chicago Press.

Care of Psychiatric, Alcoholic or Suicidal Patients

(*Continued from page* 29)

to harbor the insane, feebleminded, aged, etc."

Some of the western hospitals have experienced difficulty in obtaining protection by the R.C.M.P. for attempted suicides, and it is suggested that a ruling on this would be welcome, in order to avoid argument and overcome delay. Under the Alberta law it appears that there is no charge that can be preferred against these people, and until such time as this is remedied the police are handicapped. Urban residents, of course, are guarded by the police. Another hospital experiences difficulty in securing police protection as the police department does not like having three men employed on shifts for just one patient, and the staff doctors object to having the policemen around. The police quite often decide not to lay a charge in order to avoid the expense of placing a guard with the patient.

To overthrow superstition, to protect motherhood from pain, to free childhood from sickness, to bring health to all mankind; these are the ends for which throughout the centuries, the scholars, heroes, prophets, saints and martyrs of medical science have worked and fought and died, . . .

—*Yandell Henderson*